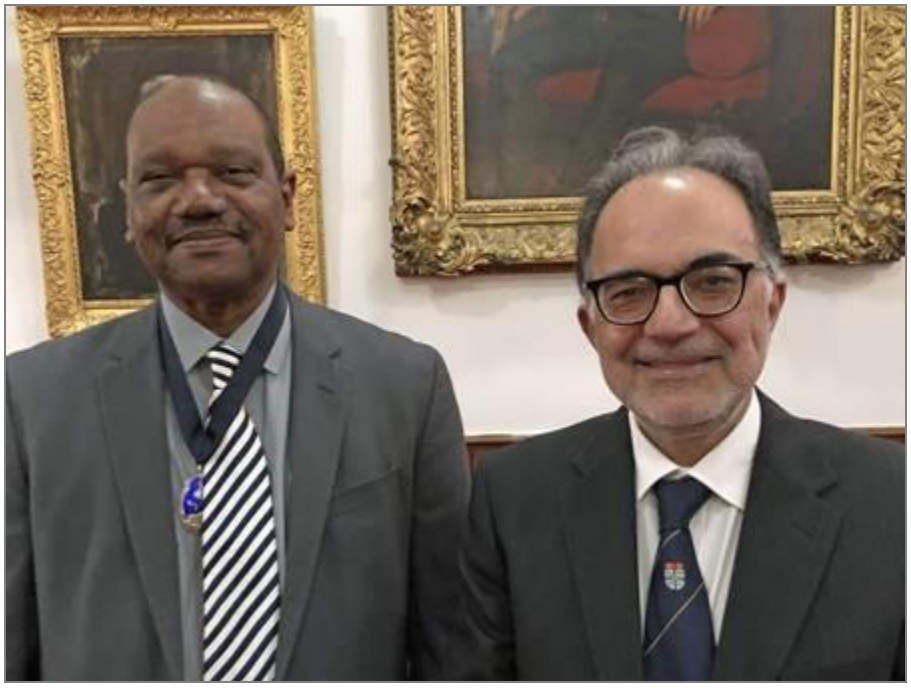
Minutes of the First Ordinary Meeting

Held on Thursday 10th January 2019

Joint Meeting with the Liverpool Society of Anaesthetists

'Quality Improvement, Perioperative Medicine & the Royal College of Anaesthetists'
Professor Ravi Mahajan



Mr Derek Machin, LMI Past-President, opened the meeting for Dr Ed Djabatey, President of the LSA who then introduced Prof Ravi Mahajan, President of the Royal College of Anaesthetists, our speaker for the evening and gave a short biography.

Prof Mahajan laid out his plan of how the RCoA was addressing the Quality Improvement (QI) and Perioperative Medicine (POM) agenda. He started by outlining the current climate and threats in the NHS and the opportunities for QI, POM, leadership and spheres of influence. He described how the RCoA started out as a faculty in 1948 with 50 members and 2 staff members to where it is now, having 2 faculties (Pain and Intensive Care Medicine), 22,500 members, 100 staff and several departments including communications, clinical quality and research.

Prof Mahajan described the traditional role of the RCoA in setting the curriculum for training leading to the awarding of CCTs, equivalence, education and CPD. It now has new roles in GPAS, ACSA, and working with the NHS research centre in projects such as NELA, PQUIP, NAPs, SNAPs as well as its involvement in the QI agenda. He described the ways that the RCoA works in partnership with many other Colleges, the DoH as well as patient led bodies.

He went onto describe the challenges in POM with 10 million surgeries in the UK per annum costing £16bn, a shrinking budget with the NHS getting into more debt year on year. He spoke about the workforce challenges with staff shortages everywhere including anaesthesia. He also commented that the patient population is getting older with more co-morbidities. By the age of 50 years, 50% of people have 1 co-morbidity and by 65 years old, 65% have multiple comorbidities. He said there are many stresses on the NHS and all the criteria in relation to quality of service are under stress.

He showed a slide on global healthcare system performance rankings commenting that overall, the UK is top ranked compared with other countries however, in terms of outcomes, we are one of the worst. Consequently, there is an opportunity to improve healthcare outcomes by looking at other ways of delivering it with money not necessarily being the answer.

He defined QI with it being the recognition that something requires improvement (by gathering data, measurement, outcomes), considering an intervention (a discovery, synthesis of evidence, bundle of interventions), implementing the intervention (this is where leadership comes in and initiatives are needed), followed by reassessment of the efficacy of the intervention (by looking at data and outcomes). QI is therefore translating evidence into practice, which looks simple, but in practice requires hard work and enthusiasm. In terms of outcomes, different ones are important to different groups (anaesthetists, surgeons, patients, managers, commissioners). He spoke about population health outcomes such as getting back to normal life, back to work, hospital free days and disability free survival. He wondered whether or not we are giving these outcomes to our patients?

Prof Mahajan went onto talk about the audits applicable to anaesthesia and POM, particularly the National Emergency Laparotomy Audit (NELA) and Perioperative Quality Improvement Programme (PQUIP). He said PQUIP used evidence and data to improve the care of surgical patients and described the top 5 national PQUIP improvement opportunities for 2019: tackling perioperative anaemia and diabetes control, individualised risk assessment, individual pain management and enhanced recovery, aiming to get patients eating, drinking and mobilised in 24 hours.

He spoke about some of the evidence base as presented in the January 2019 issue of the 'British Journal Anaesthesia' which had papers about prehabilitation, prognostication, shared decision making, psychological support (reducing opiate use post operatively), optimisation, enhanced recovery, and planned postoperative care. It was already known that these have an impact on outcomes. He showed a slide demonstrating the average length of hospital stay (LOS) for several different surgical specialties and the impact of complications increasing this markedly by 3-4 times. He commented on the effect of prehabilitation and how it can reduce complications by 50% consequently reducing average LOS markedly. He thought that a perioperative pathway should be a priority healthcare issue as this can directly impact on the public health frame work however commissioners need to better understand this.
Prof Mahajan said the challenges for us were to achieve personalised care that work in an integrated service with seamless data transfer allowing everything to happen at the right time with the measurement of outcomes and their impact on the public health framework. He argued that although we do need specialist knowledge, we also need to move away from the mind-set of merely being anaesthetists in a theatre but more of being perioperative doctors with wider more general knowledge and skills.

He went on to describe the sphere of Influence that the College is trying to establish in this area through the creation of a centre for perioperative care with an inaugural meeting in the pipeline. The role will be to look at the healthcare evidence base with the production of policy documents to convince commissioners that this deserves investment.

In summary, Prof Mahajan thought that, despite the challenges in the NHS, we have huge opportunities to influence the development of individualised care, shared decision making and integrated services to improve population health outcomes.

He then took some questions from the floor and the vote of thanks was given by Prof J M Hunter.

Dr Gemma Roberts
Honorary Secretary, LSA